and a students had a lot to learn by just watching what they did and the way they thought. It's not so popular any more. And I think that if medicine continues on the path that it seems to be taking about being a business, we are heading ourselves into a future that I don't think we're going to like as well as we liked the past.

Do you remember when Mr. Clinton campaigned, he was talking about 34 million people who were uninsured or under-insured. When he was talking about his health care reform, as president, that had gone up to 43 million. And it's someplace above that now. I think there's a day ahead of us when the critical mass of people who are uninsured will be so heavy that they can't stand it, nor can we who are insured stand by and see them deprived. And I think when that day comes, there will be a real sea change in the way we practice medicine in this country, and that's when I see us moving into a single-payer system that we will do at a time when every other country that's used it has weighed it in the balances and found it wanting. It's kind of the wrong time to go. But I think it is almost inevitable, and it will happen because people say,

"Well, we've tried everything else."

We really haven't tried anything else. Both the Democrats and the Republicans, ever since Mr. Clinton's health care plan failed, are afraid to talk about a big plan. If you look back on the history since 1993, there are no big plans that are discussed about medicine and health, and yet the problems are bigger than they ever were before. Talk about this little thing down here, we'll fix that and nobody will notice it and they won't get mad at us, and then we'll fix this little thing over here. Well, by the time you fix the third thing, the first one's broken down again, and you know, you're going around in a circle.

And I think that there is a way out of our troubles that nobody has ever tried and nobody talks about, and that is to have the care of patients managed in a public/private partnership. I think public/private partnerships have a great advantage of a private sector keeping down fraud, waste and abuse, and the public sector being able, by regulation and legislation, to set the parameters within which they think medicine ought to function. But, there's one thing missing. And I think

that we could take a page from the book of the economists and we need, in medicine, what the economists have in the way of the Federal Reserve Board. And --

INTERVIEWER: Let me just flip the tape over.

(End Tape 2, Side A)

INTERVIEWER: Tape 2, Side 2. The Federal Reserve Board.

DR. KOOP: I think it's possible to have a medical board that sits between the government and the public/private partnership, that takes care of the health of America. And I am sure that there are enough men left in medicine who don't have overpowering financial connections to some clinic or some legal enterprise, I think there are enough people who are not seeking personal aggrandizement, I think there are enough people who are not trying to squeeze the last dime out of medicine, who would welcome the opportunity to act in an advisory capacity, just like the Federal Reserve Board does. It has an understanding of economics and that's why it can make its decisions. This board would have an understanding of medicine, where it's been, where it could go, and can guide its

direction that way, and can respond to the things that happen in medicine that bother people.

I mean, if you talk to the average patient today, he doesn't have much to say about what a wonderful experience he had. It's all the problems he had. And when I talk to a stranger about my medical problems, they say, "Wow! If that's happening to you, what do you think is happening to me?" And it's a really serious question to ask.

And I think we need that kind of thinking and not -- it seems to me that we're stymied in sort of a quagmire of lack of innovative creativity as far as what medicine could be. If we look at the things that made medicine great, and we had a board and a private/public partnership that tried to guarantee that those things were sacred and sacrosanct, and would never vary for future generations of patients, I think we could restore medicine to what it once was.

One of the things that is of greatest concern to me is that when I was a young man, no matter whether it was in a Reader's Digest or Vanity Fair or Fortune magazine, any poll put the medical profession at the

very top of everyone's list for respect and awe. Now we're number 17. And we should have nipped that in the bud when we got to be number two and three. But it's pretty hard to come back from 17.

But the pride that an individual has that he is responsible for the way his profession is accepted, I think is gone. And when I talk about doing something in medicine now, with a medical reserve board and public/private partnership, then I think I could go back and I would think about the medical student who hasn't yet become a medical student. But he is up to his neck, trying to find a way to get in medical school. He wants this more than anything else in the world, and so he spends four years in college worrying about that and preparing himself intellectually to be that. But nobody in our profession says, "Welcome to the guild. Let me tell you some of the things you're going to love about medicine."

We could build into college students who are heading for medical school a loyalty to the profession, a disgust with people who abuse the profession, and we could turn it around to be what it was in the days of

our parents, when they really had tremendous respect for doctors, and doctors in turn respected them. We don't have that now.

INTERVIEWER: The amount of malaise and complaint that you hear within the profession today is quite profound. I mean, for a long time I wrote it off as disgruntled people getting more press than others, but the more I travel and talk, the more folks I hear are unhappy. And I'm sure you hear the same thing.

Is this failed expectations? Is this greed not being satisfied? Or is this that the ground really has shifted, and people who went in with reasonable and noble expectations have been poorly dealt with by the profession. What do you think is going on?

DR. KOOP: Well, I think the first thing that's wrong is that a young person that goes into medicine doesn't feel that the day he steps over the line and joins the guild, and he has responsibilities to that profession and to himself and to his patients, and there's a code of ethics and there's a code of behavior. Doesn't realize that any more, and that we have to get back to. I've already covered what I think the

governance should be in the way of a medical board and a public/private partnership.

And then I think we have to work on the individual and his profession, and you can't get into medicine very far without doing something about malpractice. And I mean, the things that have happened in the practice of medicine, I mean, they should have been nipped in the bud in the beginning. I mean, how can a physician do his bet for a patient if, on the first occasion when he sees that patient, his patient brings a lawyer with him, to be sure that everything is done in such a way that they can sue at the right time if it doesn't go right.

And there is a way -- I practiced medicine -- actually practiced medicine after all my training was finished, from 1945 until 1981. And I had all kinds of problems. I was in a brand-new specialty, and I did things that nobody ever did before. And I never got sued. Now, why didn't I get sued? Because I made the patients' parents allies with me against the problem their child had, and we fought it out together. But that takes an effort, and it takes an understanding of

what makes people unhappy about their doctors. But it's a teachable thing. I mean, you can't teach some virtues, but you can teach the practicality of getting on the right side of your patient so he doesn't sue you when things go wrong.

INTERVIEWER: Is the changing demographics -- more women, and the changing environment, where professions in America perhaps are not what they once were, that leisure time has become a more important phenomenon, is that impacting the profession?

DR. KOOP: Yeah, I think it is. When I was young, we were looking for training jobs, we wanted to know what their autopsy record is. Now what people want to know is how many nights you have off. And how much money you get paid, and so forth and so on. And so there has been a shift in that. Some of those things are inevitable over the passage of time and the growth in the complexity of the profession.

But I think we have to be more frank about our problems, and we have to address them as problems and find solutions to them. If some large international corporation, like Sony, were having relationship

problems between the people who worked for Sony and the people who bought Sony products, they would either have to fix it or they'd be out of business. And we've got to take that attitude, and that's why I say you have to start in college, you even could start in high school.

You know, if you study the guild system in Britain, didn't matter whether you were a chimney sweep or a butcher or you were a doorman, you were proud to be that, and you wore a uniform that showed that you were, and you knew what was expected of you and you knew what was a line you didn't step over. We don't raise people to feel that way any more.

INTERVIEWER: Your theme about business and medicine, theme since it impacts many of your diagnoses, is there a way back from this? I mean, once upon a time there was a belief that medicine was a profession relatively untainted by business concerns. You didn't advertise, for instance. You allegedly saw the poor and charged them what they could pay, or didn't charge. You taught for free or little recompense. And those traditions have largely fallen by the wayside. And business has roared into medicine.

Is there a way back out of that?

DR. KOOP: There's not an easy way, and there's not a quick way, I don't believe, out of that. But it's going to take a generation to change it, but I think that well-meaning in planning that generation and keeping tabs on the way it works can bring it about. But you know, the attention span of people is very short. And to tell the people who are critical of medicine, "We can change it, but it won't be until this college student has gotten to the age of 40, when he's practicing medicine, and he's only 16 now," well, that's a long time to wait.

But I think if you don't change it, you're going to lose it all.

INTERVIEWER: I mean, I do see the ground shifting in ways that it's hard to imagine it shifting back, not only in medicine but around medicine. I mean, the first person whose story I tell in "Big Doctoring," which you probably heard, I think I read a quote from him, Eugene McGregor, who practices up here in a little town -- or Lebanon, "All is life," was sort of the classic old-model GP, and he referred to younger doctors

who came and had practice and moved, as "gypsy doctors." "We were gypsy doctors in my day." Of course, he practiced in one place for 40 years. But it's kind of a gypsy society, at least compared to the rather more staid society. And I find it hard to envision, I mean, the values that you describe make a lot of sense to me, appeal to me, but I don't see how teachable that is, I guess is the question I'm asking. I mean, you can teach a higher level of awareness, but the society is a different society.

DR. KOOP: Well, you can't teach a society not to be mobile. But you can teach a doctor, who is taking care of a member of that mobile society, how to approach the patient on a new arrangement. Guy used to live in Des Moines, Iowa, his business changed and how he lives in Brooklyn, New York, and the culture is different and the climate's different and the pay is different and everything is different, but here's a doctor who still feels the same way toward him. I think that's doable.

INTERVIEWER: And I must say, I see in young people in medicine, and clinically I work with medical students and pediatric residents, there is an awful lot

of idealism in those folks, to be cultivated, cultured, nurtured. I mean, that's, to me, the most sustaining thing, the people who go into it are good people.

DR. KOOP: You're absolutely right. The thing that impresses me most about medical students today is that you never hear them talk, as you used to hear them talk, about the accumulation of wealth. They are not ashamed to say, "I'm going back to Bridgeport to practice because that's where I was born and that's where they need me."

And the thing that proves to me that they mean what they say is that the average student that comes to this medical school has had two years minimum between the time he left college and the time he went to medical school. And in that period of time, he has almost always spent that time doing some beneficial service to society. And it's because he wanted to, not because he wanted it on his resume so it would get him into medical school.

INTERVIEWER: Tell me more about your view now of specialism and generalism. We talked about specialism in surgery. And I know the Koop Institute

has been a pusher of primary care ideas over time. How have you seen that play out, and where do you see it going in medicine, in the division of labor.

DR. KOOP: Well, when I came to Dartmouth, 29 percent of medical practitioners were in primary care. And that got up almost to 45 or something --

INTERVIEWER: When you came to Dartmouth this time around?

DR. KOOP: Yeah. When I was 72.

INTERVIEWER: That would have been '94? '5?

DR. KOOP: I'm 87 now, you can figure it out.

INTERVIEWER: Well, when you left --

DR. KOOP: It was two years after I left the government, which was in '89.

INTERVIEWER: So 29 percent then. And as high as 49?

DR. KOOP: Got as high as about 45 percent in some parts of the country, and now it's drifting back again because the same things that led people away from primary care are at work in the whole business of medicine. The pay isn't as good, hours are worse, the leisure time doesn't exist, and there is still, on the

part of specialists, an unreasonable failure to understand the real contribution of the primary care doctor, who has to know a little bit about such a huge amount of stuff. And there's nothing that makes me madder than to see a professor of medicine humiliate a medical student on grand rounds, because he says, "What do you expect to do with your life?"

He says, "I'm going to join my father in the family practice."

It's as though he committed a sin and went into prostitution.

INTERVIEWER: That does happen.

DR. KOOP: Yeah. And, you know, I am surprised at the way it's happened. I'm surprised that -- I'm not surprised at the change in gender. I think women are kinder, gentler people, and I think they're good for medicine. And I think there's no reason why they can't do specialties that people used to think were only for men. Surgery, for one. A lot of very good female surgeons around.

But I do see the pull in every way -- economics, leisure time, prestige, importance, self-

esteem -- that goes with specialization, as compared to primary care. And the primary care doctor has to have his feet on the ground. He has to know himself well enough to know that he's making a contribution that a specialist can never make to medicine. And he has to know that that's what brings him satisfaction and not envy.

INTERVIEWER: One scenario for the future is that medicine will become increasingly the domain of specialism. And that nurses and others will inhabit the realm of primary care as, to some extent, they've done already. Is that a plausible outcome or a plausible possibility? And if so, would that be good or bad?

DR. KOOP: Well, with the caveat that all people aren't the same, I think that it makes good sense to share the burden of primary care with people who can handle certain things, but I think it is a mistake to say that because a nurse has taken two years of training to be a nurse-practitioner, that that makes her equivalent to a primary care doctor. And I think that is a tendency that you hear criticized by primary care physicians, and it's a tendency that nurse-practitioners

aid and abet by believing it.

INTERVIEWER: My concern is that if medicine does not take a firm stand for primary care, beyond the rhetoric -- that is, structuring payment so there's some pay equity, structuring values so that primary care is valued and supported in terms of research, in terms of training, we will have a profession that, because of the inevitable lure of technology and money, will become largely balkanized into specialties, with no base.

DR. KOOP: Right.

INTERVIEWER: And I think the nurses and others will -- because primary care is necessary. Society says it needs it. Others will migrate in and populate it, but medicine will essentially have become a domain of specialists, which to me would be a great loss. But I think is a possible outcome. I mean, that's the doomsday outcome, from my perspective. Hope not.

DR. KOOP: No, I've spent a lot of my time in the U.K., watching that system work, and there isn't the same split that there is -- they have more primary care doctors. And they have fewer specialists. They

should go together, but they don't always. And I think that the differences in income are not as exaggerated as they are in this country.

And one of the things, while we're on that subject, might be settled by having the federal medical board that I was talking about a bit ago, but what's disturbing to me is that the knowledge that a primary care physician has is not appreciated and is not compensated, but if he has a gadget that he can use on a patient, he does a technical procedure, and he suddenly can become a quote, "specialist," by buying the gadget.

And I think that there are some other things in medicine that we have talked about that are affecting the future. One of them is something that nobody talks about much -- I do, all the time -- and that is the great advances in medicine and surgery have made a lot of acute diseases chronic. We can't afford that. We can't afford it as a society, and we can't afford it financially.

One of the other things that bothers me is if you were to ask the question to a totally honest audience, unable to give you a false answer, why has it

taken us so long to do some of the things that we do? For example, as the treatment of the cancer program becomes such big business that there are forces at work that don't want to see cancer moved toward cure because that would change the balance of economic power. Very difficult questions to ask, and even more difficult questions to answer.

INTERVIEWER: I mean, I've heard those charges often from what I'll call the "Rodale Community." I mean, the kind of health food fringe.

DR. KOOP: Oh, yes.

INTERVIEWER: That -- _____ cancer, but about other -- about disease in general. Do you think there's credibility at all that there are physicians or clinicians or clinical specialties that don't want to see progress because it would be bad for business?

DR. KOOP: I think the more that our profession becomes a business, the more you'll see that sort of thing.

There was a certain purity that professionalism delivered to medicine, and when it is contaminated by greed. . . . The average guy that went

into medicine, even now, he does it for entirely different reasons than the average guy that goes into business. Has to make money, to be sure. But that's not the end-all and be-all. And that is one of the things that I most enthusiastic about in the future, is that the medical student of today seems to have lost that greedy outlook for the future that his predecessors had 25 years ago.

INTERVIEWER: Speaking of idealism, global health. Where do you see the role for the United States in global health? Where have we been? Where are we going? Is it something we have done well with or not?

DR. KOOP: Well, global anything is kind of frightening.

When you treat a problem globally -- let me start it a different way.

The only thing that I am absolutely certain that we have globalized is the spread of disease. We have really done that very well.

INTERVIEWER: "We," United States, or --

DR. KOOP: We, all of us, because of transportation, communication, and reliance on quick

treatments, quick fixes, rather than prevention. So that that's a fact of life, I think, today. And if we have globalized disease, we certainly have the obligation to globalize health.

And it seems to me that there was always a huge barrier to the globalization of health, and that was it would take so long and so much money to build the infrastructure in, say, a developing country, that you might lose sight of your goals before you ever achieved them. But two things have happened that have changed that.

One is the invention of the cell phone, and the other is the Internet.

And with the Internet and the cell phone, you don't have to build that infrastructure any more Because instead of having to go through all the stuff that's down here that used to be called infrastructure, now you can go from here to here, and here to there. And therefore I have real hope for globalization, if it doesn't destroy the little man in the process. What I mean by that is, if you globalize everything, then you're going to have Wal-Marts and K-Marts instead of

individual shopkeepers. And I don't know how you're going to manage the economic side of the change to globalization if you deprive people of their livelihood. So I think that that's something that has to be an economic arm that has to be discussed whenever any of these things are talked about that are global.

I think that one of the things that I always wanted to do when I was Surgeon General, was to have an international health corps, the way we had a national health corps, because I didn't mean to have people leaving these shores and going and doing hands-on care in underdeveloped countries, but I saw a corps of capable trained people transmitting the know-how to other people, so that they could do it on their own. And I think that's the real challenge of globalization of health care, is that you don't just import the treatment but you import the understanding so that they can develop their own system.

And I think that's all the more important when you try to recognize the cultural differences that we have -- we have them in this country and we don't _____ them. It's a totally different cultural

challenge to talk against smoking in Utah and California, than it is in Kentucky or Virginia. Totally different. We have the same people, we speak the same language, but it's totally different. It's increased in complexity when you're talking about a sub-Saharan African country and something that's attached to India. And that is going to be the hardest thing, I think, to learn because you can't treat different cultures with the same, as I said, the accoutrements of medicine. It takes more than just the pill.

INTERVIEWER: Any likelihood of an international health corps, or -- one more question. Outside of the missionary community, it's argued, and perhaps outside of the CDC with some of its targeted efforts, we haven't done a lot to promote, certainly at a government level, large numbers of teachers, clinicians, going abroad. Any prospects that we'll be doing that?

DR. KOOP: I think there are theoretical reasons why it should work now better than any time that I've been alive, because you have more disgruntled physicians leaving medicine because of the things we've

been talking about, than ever before.

INTERVIEWER: Who might be recruitable?

DR. KOOP: They're recruitable. And you know, the thing that I have seen, you take somebody who's never been off on an altruistic mission to help somebody in another country, the first time he does it it's like a new world to him. He just can't believe how great it is. And they go back.

(Interruption)

If you think about how the Peace Corps came about, that didn't take a lot. It took one man talking about it, it took another man writing about it -- Kennedy, Sargeant Shriver, and it took a lot of people who, once they went, they became the advertisers. And I think there's so much to be learned, so much to bring satisfaction with some kind of a thing like an international health service corps, that it would be worth some major foundation really attempting to try it.

INTERVIEWER: Yeah. Switching gears. I want to get at least something on the record about the National Health Museum. I know it's something you've been involved with for a number of years, been one of

the leaders and thinkers about it. What would the role of a National Health Museum be in American life?

DR. KOOP: Well, what a National Health Museum should not be is just a curio shop. There is a real place in education to have some illustrations from the past about how things were successfully or unsuccessfully managed, but the challenge of a so-called museum today is that it becomes a health education center primarily to inspire the new generation about what is possible to be accomplished.

My reason in the beginning for being interested in a museum in Washington that had to do with health, was that I used to stand in my office up on the top floor of the Humphrey Building and see all these kids standing by one of the reflecting pools, getting their pictures taken, when they came on their senior trip to Washington, and I kept thinking about the wonderful opportunities that they had, and then it occurred to me that they could be stimulated to be almost anything in the world by what they saw in Washington, except something in medicine and health. Because there's no place to see it.

And I think that still should be the major educational effort to get young people to commit early to a life of health and medicine and science that leads to the betterment of the human condition, but there are so many things that you can tack on to that to make it interesting, that I think it's a great idea.

INTERVIEWER: Good. The Bushes. We talked a little bit about George Herbert Walker and a kind of transition, but you've seen the Bushes as presidents and worked to some extent with them and their people. Any thoughts about either or both, and their health policies?

DR. KOOP: I don't think -- as far as I know, there's only one person in health that has the ear of the president. I don't think one person is enough.

INTERVIEWER: This being the current president? George W.

DR. KOOP: Yeah. And that person is Tony Boucher(?). And great respect for Tony Boucher in many ways, but I think one person can't do it.

The thing that I see different about this administration from the other three that I was

associated with is that it is hard to get an answer to a health question in the White House. And I don't think that this administration really thinks it needs any guidance in the health field. And I think that that's wrong, because nobody can guide in health except somebody who is trained in health.

And off the record, this is a pretty hard group to infiltrate. Just twixt thee and me, I sat with Barbara Bush for eight hours one day, and I filled her in on a lot of things that I wanted her son to know. And I said, "I've met him socially and I've met him when he was governor, but I would like to talk to him about his presidency because, one, I know where there are a lot of minefields that he shouldn't step on, but also I know that there are opportunities for him to make an absolutely lasting contribution to the health of this nation. And I'd like to be able to talk to him about it."

She wrote it all down and she said, "Chick, I will see that he gets this the first time I see him."

And I know Barbara well enough to know that she did, but I never have been to see him.

And I think the war on terrorism has taken a lot of attention, but I think if there weren't a war on terrorism, it would still be about the same because I don't think they have the capacity to understand what we need to do.

INTERVIEWER: Being a senior statesman is a role you played well. Personally and business-wise, I know it's been a tough role. Dr. Koop dot com, in particular. If you were coming out of the surgeon generalship into your senior statesman role on the personal side, would you -- business side, would you have done it differently?

DR. KOOP: With the hindsight I have --

INTERVIEWER: Time Life Books, too, I guess.

DR. KOOP: Something that is not known by the public and I don't mind if they do know it, I think the Time Life venture is one of the best things I ever did, and I think that what remains and hasn't become antiquated by the passage of time is still state-of-the-art.

The reason that that company went bankrupt had nothing to do with that company. It had to do with the

fact that my plans were a threat to the tobacco industry, and they went to Time Life, Time-Warner, and said if I were permitted to go the direction I was going, that they would cease to advertise in People, Time, Life, Sports Illustrated. We were in business at 4:00 o'clock, and bankrupt at 4:20.

So that was an engineered thing by the greed of tobacco companies. I think I got caught up in something that a lot smarter businessmen than I got caught up in, and that is the dot.com craze --

INTERVIEWER: Yes, on that, the Time Life Books, which was supporting the videotapes and the -- what was the whole enterprise called?

DR. KOOP: Well, we called it Time Life, Inc., and we had the privilege to do that as a franchise.

INTERVIEWER: Right, but the health information video program, did it have a --

DR. KOOP: Yeah, well, that was called --

INTERVIEWER: Did it have your name on it?

DR. KOOP: No, it didn't have my name on it. No. Media Information --

INTERVIEWER: There was a program of

informational materials, videotapes in particular --

DR. KOOP: There were 34 videotapes. That was Time --

INTERVIEWER: State-of-the-art commentaries on different diseases for the layman.

DR. KOOP: Right.

INTERVIEWER: And the legs were cut out from under it financially because the company went bankrupt?

DR. KOOP: They refused -- Time and Life took their franchise away from us because they were threatened with no advertising by tobacco industry.

INTERVIEWER: Is that something you're willing to -- if I include that in the new --

DR. KOOP: I've said it publicly before.

INTERVIEWER: Okay, good. And drkoop.com.?

DR. KOOP: drkoop.com, we -- you know, the first year we got every prize that you could get in the world of the Internet for what we did with that thing. We really kept the data up-to-date, so forth and so on. But competition was just too tough. There were too many people in the business, and I don't want to say this, but I'll tell you, one of our competitors was

Med -

INTERVIEWER: MedScape? Web, M.D.?

DR. KOOP: Web, M.D. And you know how they're financed? Any time they need any money, they just call Bill Gates and he gives it to them. Can't fight that. And Web, M.D., has not been for the benefit of the public since that time. It's for the benefit of the doctors saving money by having electronic ways of handling their business.

(Recording interruption)

INTERVIEWER: We were talking of drkoop.com. Anything else -- I mean, I know it was an awful episode for you, to sort of take the thing public and have as much attention to it, and then have it fail.

DR. KOOP: Yeah.

INTERVIEWER: Is that --

DR. KOOP: It was a very disappointing thing, and fortunately I had lots of other interests, and so it -- I seldom think about it now. I'm not sure that if I did it again and that I could weather the storm any better. Because it was just -- just thousands of health sites failed.

INTERVIEWER: Yeah. I mean, certainly, with your interest in communication and the explosion of the Internet, the two seemed destined to work together, and that they came together and then it didn't work is just -- I mean, a disappointment to you, a disappointment to me.

HIV and the world. A problem. You were there when it started. Where do you see it today?

DR. KOOP: Oh, HIV and the world is a disaster. There are countries with 38 to 40 percent HIV positivity, in sub-Saharan Africa. The people that I talk to who know what's going on in China say that the future there is grim, because there has been such a population shift from central China to coastal China, which is where the business opportunities are today, that by being introduced in coastal China also introduces a naïve population to the sexually oriented population, and there is very little understanding about the transmission of the disease by these country folks who come in to town. And so public health people in China are looking forward to a disaster they don't know how to handle.

I think that the obligation of the United States in all global health problems is to share our knowledge and to share our know-how and, where possible, to put in seed money, and I think that the fact that Mr. Bush has included that in his plans is very good. I think it's a good sign that some of the pharmaceutical houses have changed their pricing structure for places like Africa. But when a country like South Africa still refuses to believe that HIV is the cause of AIDS, we have a very serious problem.

And we do know, by the way Uganda has changed its educational program and has changed its culture, to some degree, that AIDS is not an insurmountable problem even in a culture like that. So I think that it needs organization, there ought to be some kind of African-Asian consortium that worries about this.

Compared to the United States, the rest of the world is in terrible shape. The United States, because it's an affluent country and because we know about giving AZT to pregnant women and because we know about fancy therapeutic cocktails, it's possible now to be diagnosed with AIDS and to live out your life expectancy

and die of something else. But that's at the cost of $20,000.00 a year per person.

INTERVIEWER: A final question. As you look back on your career, thoughts about it?

DR. KOOP: I've had a very, very interesting life, and I really feel that I was born at a good time, because I lived through what I think is the golden age of surgery, tremendous technical advances, but in the midst of it was very much a part of the development of pediatric surgery, which was a special privilege.

My time as Surgeon General was one of the happiest and I think most productive times of my life. And the fact that I'm 87 and still active and still lecturing and still teaching here, is -- it's enough to raise your eyebrows.

(Laughter)

INTERVIEWER: That's a good place to end.

DR. KOOP: Good.

(End of proceedings as recorded.)